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TO: Each Supervisor

FROM: Bruce A. Chernof, M.D.
Director and Chief Medical Officer

SUBJECT: **RECENT BUREAU OF NATIONAL AFFAIRS (BNA) ARTICLE RE: REPORT BY FEDERAL DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL (OIG)**

Attached for your information is a copy of a recent BNA article (attached) regarding the OIG report to the Federal Centers for Medicaid and Medicare Services (CMS), released on November 7, 2006. The title of the BNA article is "California Unable to Account for $550 Million in Funds Claimed for Demo Project, OIG Says."

The BNA article is misleading in that is implies that the demonstration project funding was in some respect misused by the County. Of course nothing of the kind occurred, nor was that a finding of the OIG. The author of the article clearly does not understand the complex funding mechanisms authorized under the County's 1115 project. This is particularly troublesome because the BNA publication purports to be expert on health care issues and should have the expertise necessary to accurately analyze the OIG Report.

The OIG concerns arise from (1) the use of state disbursements rather than project expenditures as the basis for the match; and (2) the fact that a portion of the funding was retained in a reserve for health care services in future years. As the OIG recognized, however, both factors were consistent with the approved terms of the project. As a result, the OIG did not criticize either the State or the County, but instead made recommendations regarding the approval of future projects.

Indeed, the BNA article does note that:

> "The OIG found that the state followed the requirements of the 1115 waiver project extension agreement when claiming federal ambulatory and supplemental funds and adequately supported the cost of outpatient services."
>
> "However, the county was unable to identify specific costs incurred as they related to $550 million in claimed supplemental expenditures, of which $285 million was the federal share, according to the OIG's report..."

Although the article does state that: "The report noted that the demonstration project extension agreement did not require that the claims be based on costs incurred by the county or state for specific services..." this critical finding is underplayed and the BNA article implies that somehow the County should be able to identify the exact expenditures paid for by the Supplemental funds.

This implication is, however, contrary to general statements of policy made by two former CMS administrators, Bruce Vladeck and Tom Scully. In deposition testimony given in a recent lawsuit against the County, both men acknowledged that Medicaid money is fungible with other revenue and need not be tied to particular patient care costs. Notwithstanding CMS' attempts to change federal Medicaid law, and its threats to issue Medicaid regulations limiting public providers to cost-based reimbursement, nothing in the law or in the terms of the Waiver limited the County to reimbursement for its costs. Therefore, the County properly received payments in excess of its costs.

It should also be noted that CMS approved the Supplemental fund arrangement with the County, using intergovernmental transfers, four separate times with respect to the ten years ended June 30, 2005, during which CMS granted the 1115 waiver to the State and County. In fact, the current State 1115 waiver under which Medi-Cal Redesign is being implemented, continues to provide for some intergovernmental transfer-funded Medicaid expenditures which will not be specifically tracked to a provider's expenses.

The reason why these non-cost based payments, which both CMS Administrators Vladeck and Scully describe as "fungible", cannot be matched to specific expenditures is illustrated by the following example:

> Suppose an individual deposited into his bank account three checks from different sources in the amount of $100 apiece. He then writes a check to his gardener for $150. How much of the $150 was paid from the bank account's preexisting balance, and/or from each of the three checks deposited?
>
> The answer is: "It cannot be determined because all of the dollars in the bank account are fungible."

This demonstrates why neither the State nor the County can identify the specific uses of the Supplemental funds referenced in the OIG's report. When these funds were paid by the State to the County, the federal portion was deposited in hospital enterprise funds, which had preexisting balances and into which went deposits from a variety of other sources, and from which payments were made for a wide variety of expenses.

The OIG notes, in its cover letter (page 2) to the current CMS Acting Administrator, that "County documentation indicated that Supplemental disbursements had contributed to a reserve fund of approximately $306.4 million accumulated by the County Department of Health Services." Such use, however, was perfectly consistent with the goals of the extension period waiver. According to the County's 1115 Waiver's Special Terms and Conditions, the federal funds afforded under the Waiver were to be used "...to continue to

assist the County in restructuring its health care delivery system to ensure its long term fiscal viability..." (underlining added for emphasis). It was not uncommon, or unexpected that, in addressing the "long term fiscal viability" of the County's health care system, that efforts were made to obtain and reserve funding from all sources, including federal waiver funds, in an attempt to establish reserves which could be available for use in future fiscal years. To place this practice in its proper context, the "County documentation" to which the OIG refers, is an October 7, 2004 memorandum to the OIG, which states, in part:

> "The available federal funds, as well as the State's general fund match for cost reimbursement of our hospital and non-hospital clinic services to Medi-Cal eligibles have also helped us maintain our current service levels and helped build a reserve (Designation Fund), which the County will draw upon to delay potential future service reductions. As indicated on the attached schedule..., this Designation Fund was established by the County's Board of Supervisors to ensure that any revenue and operating subsidies received by the Department in excess of expenses are reserved for future use by the Department only."

It is also worth noting that the current statewide waiver specifically recognizes that IGT funded amounts may be retained for use in a subsequent year.

I hope the preceding sufficiently explains why the State and County are unable to match the Supplemental funds received to specific County expenditures and why that fact does not mean that the County acted improperly or misused funds under the waiver, as understood and approved by CMS.

Please let me know if you have any questions or desire further information.

BAC:gww
(BNA ARTICLE REGARDING OIG REPORT)

Attachment

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors
County Legislative Strategist
CMS Administrator
California Secretary of Health and Human Services
California Director of Health Services
California Director of Medicaid
California Hospital Association
National Association of Public Hospitals
California Association of Public Hospitals
Bureau of National Affairs

Poolman said he had asked Blue Cross to develop a plan for ridding itself of excess reserves after determining that the company's risk-based capital was greater than 700 percent. Given that Blue Cross has a 90 percent market share in North Dakota, he said, it was believed that the insurer could reduce its surplus and still be in an "incredibly healthy" position.

He said Blue Cross could have offered its subscribers a premium holiday or it could have reduced its premium rates to decrease its surplus. It is likely the company opted for the refunds since they are administratively easier than the other options, he said.

Poolman said his office did not have the legal authority to require Blue Cross to divest of its excess surplus and that the company could have ignored his request. Had Blue Cross not acted, the Insurance Department likely would have asked the 2007 Legislature for the legal authority to reduce excess surpluses, he said.

Gauper told BNA earlier that while the insurer tries to keep three to four months of reserves, a decrease in claims over the past year left Blue Cross with a significant surplus.

California

State Unable to Account for $550 Million In Supplemental Medicaid Funds, OIG Says

California Medicaid officials are unable to demonstrate exactly how nearly $550 million in funding from a Section 1115 waiver project extension was spent in Los Angeles County between 2001 and 2004, the Department of Health and Human Services Office of Inspector General said in a report released Nov. 7.

The OIG found that the state followed the requirements of the 1115 waiver project extension agreement when claiming federal ambulatory and supplemental funds and adequately supported the costs claims for outpatient clinic services. However, the county was unable to identify specific costs incurred as they related to $550 million in claimed supplemental expenditures, of which $285 million was the federal share, according to the OIG's report *Audit of California's Section 11 15 Medicaid Demonstration Project Extension for Los Angeles County* (A-09-04-00038).

Section 1115 of the Social Security Act gives the health and human services secretary the broad authority to waive certain Medicaid law requirements, so that states can carry out demonstration projects and continue to receive federal funds. The OIG's audit covered ambulatory service costs and supplemental project costs claimed by L.A. County under a five-year extension of a Section 1115 waiver project intended to help the county restructure its health care delivery system, ensure its long-term viability, and reduce the county's reliance on federal demonstration funds, according to the audit report.

During the four-year period the OIG audited, the county claimed $1.6 billion in ambulatory and supplemental expenditures, of which the OIG expressed concern over the $550 million in claimed supplemental expenditures.

The report noted that the demonstration project extension agreement did not require that the claims be based on costs incurred by the county or state for specific purposes, although the purpose of the funding was

ATTACHMENT A

to offset disproportionate share hospital payments lost as a result of reduced inpatient hospital utilization of the waiver, the OIG said.

"An agreement for a federally funded project should contain an accountability requirement to ensure that Federal funds are spent in accordance with the purposes of the project," the OIG said in its summary of findings. "Without such a requirement, there was no assurance that the county used the approximately $549.8 million in supplemental funding for the intended purposes."

Instead, the OIG continued, it appeared that some of the supplemental disbursements went toward a $306 million reserve fund held by the county department of health services.

The OIG recommended that for future demonstration projects, the Centers for Medicare & Medicaid Services should deny or limit the use of federal funds for reserve accounts.

CMS agreed with the recommendation.

The report is available on the Web at http://www.oig.hhs.gov/oas/reports/region9/90400038.pdf.

Iowa

State Reviewing HHS OIG Audit Seeking $5 Million Refund From Children's Program

ST. PAUL, Minn.—A spokesman for the Iowa Department of Human Services told BNA Nov. 8 that it is still determining how to respond to an Office of the Inspector General audit that held that the department made a number of errors in setting up a children's health insurance program between 2000 and 2002.

Roger Munns said the state soon would respond to the audit's contentions that it paid duplicate premiums, failed to document that children were uninsured, and paid premiums for applicants whose incomes did not support eligibility determinations.

The OIG has recommended that the state refund more than $3.5 million in federal payments for the program, as well as another $1.5 million in payments for set-aside cases. It also has asked the state to strengthen its quality control requirements for the children's insurance program.

The audit, released Nov. 3, contends that Iowa, in setting up its plan under the State Children's Health Insurance Program, expanded Medicaid for children with family income of up to 133 percent of the federal poverty level and created Healthy and Well Kids in Iowa (HAWK-I) for children whose family incomes were up to 200 percent of the federal poverty level but were ineligible for Medicaid.

According to the audit, OIG found that in 42 of 114 cases the applicants' records did not support the state's eligibility determinations or the administrator made duplicate premium payments to the commercial insurer on behalf of HAWK-I eligible children. The audit also contends that the state failed to document some children who were uninsured, that it offered some coverage during the waiting period, and that it was missing eligibility documentation in some cases.

The audit states that the errors occurred because the program administrator's quality control reviews were